Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 13, 2019	2019_767643_0030	013146-19, 014158-19, 014181-19, 018261-19	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 Overlea Blvd TORONTO ON M4H 1P4

Long-Term Care Home/Foyer de soins de longue durée

Isabel and Arthur Meighen Manor
155 Millwood Road TORONTO ON M4S 1J6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ADAM DICKEY (643)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 13, 14, 15, 18-22, 26, 2019.

The following Critical Incident System (CIS) intakes were inspected during this inspection:
Log #013146-19; CIS #C603-000008-19 - related to suspected improper care, Log #014158-19; CIS #C603-000009-19, Log #014181-19; CIS #C603-000010-19 and Log #018261-19; CIS C603-000014-19 - related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurses (RPN), Registered Physiotherapist (PT), Personal Support Workers (PSW) and residents.

During the course of the inspection the inspector(s) conducted observations of resident and staff interactions and the provision of care, reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #001 set out the planned care for the resident.

A Critical Incident System (CIS) was submitted to the Director for a suspected incident of improper care from an identified date, which resulted in harm to resident #001. According to the CIS report, resident #001 was found to have specified areas of altered skin integrity identified by staff. The CIS indicated that an identified piece of safety equipment had not been applied at the time the incident was discovered.

Review of resident #001's written care plan showed that the above identified safety equipment was added to the plan following the incident on the above identified date. No record was found indicating that the resident was to have the safety equipment in place prior to this date.

In an interview, RPN #119 indicated that they were working on the above identified date, when they were called to see resident #001. Resident #001 was found to have specified areas of altered skin integrity and was assessed by the RPN at that time. RPN #119 indicated that the resident had the above identified safety equipment implemented prior to the discovery of the incident, however when they went to assess the resident the equipment was not in place at that time. The RPN was unsure how long that the safety equipment had been in place and indicated that the resident exhibited identified responsive behaviours and the equipment was in place for the resident's safety.

In an interview, RPN #120 indicated that resident #001 exhibited identified responsive behaviours, and had the above identified safety equipment in place to prevent them from injuring themselves. RPN #120 was unsure how long the safety equipment had been in place but indicated that it had been implemented prior to this incident and should have been included in the resident's care plan in the electronic record.

In an interview, DOC #101 indicated that the above identified safety equipment was implemented for resident #001 prior to the discovery of the altered skin integrity on the above identified date, though it was not able to be determined when the safety equipment had been implemented. The DOC indicated that the safety equipment would have been provided at the request of the nursing staff on the unit and should have been included in resident #001's written plan of care when the intervention was implemented. [s. 6. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

Issued on this 17th day of December, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.